Appendix 1

Instructions for Completion of the Wisconsin Medicaid Home Care Assessment Form

MEDICAID HOME CARE ASSESSMENT

Wisconsin Medicaid will return the request to the provider if the Assessment is not completed per directions that follow. Unless otherwise indicated, **all numbered items must have at least one response**.

The Home Care Assessment must be completed by a registered nurse (RN), alone or in coordination with case manager. The assessment must reflect the recipient's condition as actually observed by the RN. Every item must be completed. If an item does not apply to the recipient, print "N/A" at the item.

1. Provider Information

1.1 Enter the provider name exactly as it is on record with the Wisconsin Medicaid. For home health agencies, the name should match the name on the Wisconsin home health license.

1.1 Provider Name: _____

1.2 Enter your 8-digit Medicaid (MA) provider number. Personal care and home health provider numbers begin with "4" and end with "00."

1.2 Medicaid Provider Number: _____

1.3 Enter your FAX number, if any. This will allow us to contact you via FAX, if necessary.

1.3 Provider's Fax Number: _____

2. Recipient Information

2.1 Enter the recipient's name exactly as it appears on the recipient's Medicaid ID card. Make sure to check eligibility through the Eligibility Verification System (EVS).

2.1 Name (Last, First, Middle Initial): _____

2.2	Enter the recipient's 10-digit Medicaid ID number exactly as it appears on the Medicaid ID card.

2.2 Medicaid ID Number: _____

2.3	Enter the street address, including house number and apartment number, if any, and city where recipient actually lives and receives services at the time the assessment is completed.

2.3 Physical address where home care services are provided: _____

2.4	Private insurance is not indicated on the Wisconsin Medicaid ID card. Providers should ask the recipient or the recipient's representative if he or she has any private insurance, including medical insurance through work or a family policy. If the insurance covers any of the home care services this recipient requires, bill the private insurance before billing Wisconsin Medicaid.

2.4. Does the recipient have any private insurance? ☐ No ☐ Yes

(If yes, bill the private insurance before billing Medicaid. However, providers should request Medicaid prior authorization for all Medicaid covered services, including those services billed to other payers.)

2.5	Medicare will be indicated by accessing the EVS. If Medicare is not indicated, verify this by asking the recipient or the recipient's representative if he/she has a Medicare card. If Medicare covers any of the home care services the recipient requires, bill Medicare before billing Wisconsin Medicaid.

2.5 Does the recipient have a Medicare card? ☐ No ☐ Yes

If yes, check the applicable box: ☐ Part A only ☐ Part B only ☐ Parts A and B

2.6	"Confined to a place of residence" means a recipient's physical medical condition or functional limitation in one or more of the areas listed in s. HFS 134.13(9)(c), Wis. Admin. Code, including self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent learning, which: (a) restricts the recipient's ability to leave his or her place of residence except with the aide of a supportive device, such as crutches, a cane, a wheelchair or a walker, the assistance of another person, or the use of special transportation; (b) is such that leaving the residence is medically contraindicated; or (c) requires a considerable and taxing effort to leave the home for medical services.

2.6 Is the recipient confined to his/her residence? ☐No ☐Yes

([HFS 101.03(31), Wis. Admin. Code] A recipient does not need to be confined to the residence in order to receive Medicaid-covered home health aide or personal care worker (PCW) services. A recipient must be confined to the residence in order to receive Medicaid-covered home health nursing or home health therapy, unless the skilled service cannot be reasonably obtained through another, more appropriate provider. [Refer to the Home Health Handbook for additional information.])

2.7	Answer the following question based on the RN's assessment of the recipient's needs, not based on the services your agency will actually be providing. If the recipient may be eligible for Medicare home health coverage, and you are not able to provide the Medicare-covered services and bill Medicare, please refer the recipient to another qualified provider. If answer is yes, a level of service box must also be checked.

2.7 Does the recipient need any of the following skilled services? ☐No ☐Yes

☐RN ☐LPN ☐PT ☐OT ☐ST

(If a recipient is eligible for Medicare, is confined to the residence, and needs a skilled service, Medicare must be maximized before Medicaid is billed, including supplies and equipment. However, request Medicaid prior authorization for all Medicaid-covered services, including those billed to other payers.)

2.8	Ask the recipient or the recipient's representative for the response to this question. It does not affect your ability to provide care, but may assist Wisconsin Medicaid in recovering appropriate funding from other sources. A comment may also be entered or "unknown."

2.8 Does the recipient require home care services as the result of:

A. Motor vehicle accident: ☐No ☐Yes
B. Employment-related accident: ☐No ☐Yes
C. Other accident: ☐No ☐Yes

2.9	Ask the recipient or the recipient's representative for the response to this question. It does not affect your ability to provide care, but will give a better picture of how the recipient's needs are being met. If the answer is yes, please cooperate with the county in coordinating care. If the answer is Yes, a funding box must also be checked.

2.9 Does the recipient receive county funding? ☐ No ☐ Yes

If yes, complete the following:

☐ Community Options Program

☐ Medicaid waivers (CIP IA, IB, II, COP-W)

☐ Other (specify):_____

☐ Unknown

3. Responsible Party

3.1	Ask the recipient or the recipient's representative for the response to this question. When the recipient is competent, the response may include a person the recipient wants involved, even though the person has no legal responsibility. It would be helpful if providers would circle the relationship of the person named. We may contact the person named if we have questions about the recipient's needs and how they are being met.

3.1 Does the recipient have a legal guardian, person with power of attorney, or other responsible party who must be contacted, or who the recipient wants contacted, with issues regarding the recipient's care:

☐ No ☐ Yes. If yes, complete the following:

Name and relationship: _____

Address: _____

Telephone Number: _____

4. Other Service Providers

4.1 Ask the recipient or the recipient's representative for the response to this question. We may contact the case management agency if we have questions about the recipient's needs and how they are being met. If the answer is yes, please cooperate with the case manager in coordinating care.

4.1 Does the recipient receive case management services? ☐ No ☐ Yes

If yes, complete the following:

Case Management Agency:_____

Address:_____

Telephone Number:_____

4.2 Ask the recipient or the recipient's representative for the response to this question. We may contact the agency or individual named if we have questions about the recipient's needs and how they are being met. When the table asks for the name of the individual provider, you may enter "Unknown" if the recipient or recipient's representative is unable to provide the information. We acknowledge that the individual providers will often change. If the answer is yes, please cooperate with the other providers in coordinating care. "Name of paid individual (e.g., COP worker)" may be completed with the name of an agency. "Other provider" may be a reference to the relationship (e.g., neighbor, friend, daughter) and the address and phone number is optional for "Other provider."

4.2 Will the recipient also receive home care services from another provider?

☐ No ☐ Yes

If yes, please provide the following to assist in coordination of services.

Type of Provider	Name	Street Address	City, State, Zip	Telephone
Home health or personal care				
Paid individual (e.g., COP worker)		N/A	N/A	N/A
Legally responsible spouse or parent		N/A	N/A	
Unpaid household member	Enter name or relationship	N/A	N/A	N/A
Other provider (explain)				

(Medicaid cannot be billed for parenting or services a family member or volunteer is willing to provide free of charge.)

5. Scheduled Activities Outside of Residence

5.1 Ask the recipient or the recipient's representative for the response to this question. Enter the "scheduled" absences as of the date the assessment is completed, even though the recipient may not always keep the schedule. The response to this question does not affect your ability to provide care, but it gives a better picture of how the recipient functions and assists us in determining when we can contact the recipient.

5.1 Does recipient attend scheduled activities outside of the residence? ☐No ☐Yes

If yes, provide the recipient's schedule:

Scheduled Activity	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
School							
Work							
Day Program							
Other							

6. Living Arrangement

6.1 The purpose of this item it to determine whether the recipient's housing may limit the recipient's ability to achieve independence. For example, if the recipient cannot use a wheelchair in his or her home, even though it can be used outside of the home, less independence would be achieved.

6.1 Recipient's housing is:

☐ Accessible

☐ Not accessible to wheelchairs and assistive equipment

6.2 This information is being gathered to assist us in understanding special needs that may be associated with living arrangements. It will also be used to better coordinate care. Ask the recipient or the recipient's representative for the response to these questions.

Check "Alone..." if the recipient lives in a private residence or apartment alone.

☐ Alone (Go to 7.1)

Check "With family..." if the recipient lives in a private residence or apartment, and no other person in the home is legally responsible for the recipient.

☐ With family, friend, roommate with no legal responsibility (Go to 7.1).

Check "With legally..." if the recipient lives with a spouse or if the recipient is a minor child (under age 18) and lives with a parent. The spouse or parent cannot be paid to care for the recipient.

☐ With legally responsible adult (spouse or parent of minor child) (Go to 7.1).

Check "Foster Home" if the recipient lives with a person under a child or adult foster program. Also enter the name of the foster parent or sponsor to assist us in coordinating services. Request will be returned if box is checked and name of foster parent/sponsor is not entered.

☐ Foster Home: Name of Foster Parent/Sponsor: _____

Check "CBRF" if the recipient lives in a licensed CBRF. Also, enter the name of the CBRF to assist us in coordinating services. Note that home care services provided to residents of CBRFs are limited by the Wisconsin Administrative Code.

☐ Community-Based Residential Facility (CBRF): Name: _____

If the living arrangement for the recipient cannot be identified as one of the above choices, check this box and explain the living arrangement. Request will be returned if box is checked and the living arrangement is not specified.

☐ Other (specify): _____ (Go to 7.1)

6.3 Check the box that reflects the number of persons residing in the foster home or CBRF at the time the assessment is completed. Note that home care services provided to residents of CBRFs are limited by the Wisconsin Administrative Code. If "foster home" or "CBRF" are checked under 6.2, the request will be returned if a box is not also checked under 6.3.

6.3 If recipient resides in a foster home or CBRF, how many people reside there?

☐1-2 ☐5-8 ☐16-20
☐3-4 ☐9-15 ☐More than 20

(Wisconsin Medicaid does not cover services included in the CBRF's daily rate or personal care services in a CBRF with more than 20 beds.)

6.4 Optional. This is your opportunity to provide additional information you believe we need to know to understand the recipient's needs. Although this information does not affect the prior authorization decision tree, it may be important if your request must be referred to a nurse consultant for review.

6.4 List and explain any social, economic, or cultural factors not otherwise identified that may impact on the need for home care services or how the services are provided:

_____

_____

7. History of Condition

7.1 The RN must enter a brief summary of the recipient's condition, highlighting problems which directly affect the recipient's need for care. Discuss progress or lack of progress and any changes in condition which have resulted in a change of treatment or care over the past 60 days. You may attach a separate narrative, in which case you must enter "See attached narrative" here. "See attached narrative," or similar language, is also acceptable for this item if a narrative of condition is attached. If the narrative is on the HCFA 485 or 486, specify the location on the form.

7.1 Explain in the space provided, recipient's condition and any past or present problems which directly affect the delivery of home care services at this time:

_____

_____

_____

7.2	Enter the ICD-9-CM diagnosis code, diagnosis description, and the date the diagnosis was made for all CURRENT, active diagnoses. This information must support the recipient's need for care. "See HCFA 485, #11, 12, or 13" (specify where) is also acceptable for this item.

7.2 List each diagnosis by ICD-9-CM diagnosis code and description, and date of onset for which care is required:

_____

_____

7.3	Based on clinical information, the RN must make an entry using professional judgement. The physician orders and prior authorization request must be consistent with this response.

7.3 How long do you anticipate the recipient will require ongoing home care services?

☐ Indefinitely ☐ More than 12 months
☐ 12 months ☐ Less than 12 months

7.4	Based on clinical information, the RN must make an entry using professional judgement. If the recipient may be expected to learn how to perform self-care, but not well enough to be independent, check both "Yes" and "But only somewhat." If the recipient is a child who may be expected to learn how to perform self-care in accordance with standard development stages for children, check both "Yes" and "Only at an appropriate stage." Check "No opinion" only if your experience with this recipient is too limited to make judgement at this time. A written comment, rather than a checked box, is also acceptable.

7.4 Is there potential for the recipient to learn how to perform self-care?

☐ Yes ☐ But only somewhat, or ☐ Only at an appropriate age
☐ No
☐ No opinion

8. General Assessment Information

8.1 Based on clinical information, the RN must make an entry using professional judgement. Check only one box under 8.1. Comments clarifying the response may be written in open space to the right. One and only one box must be checked. If not, the request will be returned.

8.1 Communication

How does the recipient make his/her needs known:

- ☐ 0 = Communicates needs.
- ☐ 1 = Communicates with difficulty but can be understood.
- ☐ 2 = Communicates with sign language, symbol board, written messages, gestures, or interpreter.
- ☐ 3 = Communicates inappropriate content, makes garbled sounds.
- ☐ 4 = Does not communicate needs.
- ☐ N = Child with age appropriate communication.

8.2 Based on clinical information, the RN must make an entry using professional judgement. Check only one box under 8.2. Comments clarifying the response may be written in open space to the right. One and only one box must be checked. If not, the request will be returned.

8.2 Hearing

Does the recipient wear a hearing aide? ☐ No ☐ Yes

Code recipient's ability to hear with hearing aid if customarily worn:

- ☐ 0 = No hearing impairment.
- ☐ 1 = Hearing difficulty at level of conversation.
- ☐ 2 = Hears and understands only very loud sounds, e.g., has to be yelled at.
- ☐ 3 = No useful hearing, including unable to interpret audible sounds.
- ☐ 4 = Not determined.

8.3 Based on clinical information, the RN must make an entry using professional judgement. Check only one box under 8.3. Comments clarifying the response may be written in open space to the right. One and only one box must be checked. If not, the request will be returned.

8.3 Vision

Does the recipient use corrective lenses? ☐ No ☐ Yes

Code recipient's ability to see with corrective lenses if customarily worn:

☐ 0 = Has no impairment of vision.
☐ 1 = Has difficulty seeing at level of print, but may be able to read large or thick print.
☐ 2 = Has difficulty seeing obstacles in environment.
☐ 3 = Has no useful vision.
☐ 4 = Not determined.

8.4 Based on clinical information, the RN must make an entry using professional judgement. Check only one box under 8.4. Comments clarifying the response may be written in open space to the right. One and only one box must be checked. If not, the request will be returned.

8.4 Orientation

Orientation is awareness to the present environment in relation to time, place, and person:

☐ 0 = Oriented.
☐ 1 = Minor forgetfulness of:
☐ time ☐ place ☐ person ☐ medications ☐ meals
☐ 2 = Partial or intermittent periods of disorientation in:
☐ AMs ☐ PMs ☐ 2 hours or less ☐ consistently ☐ inconsistent times
☐ 3 = Totally disoriented; does not know time, place, identity.
☐ 4 = Comatose.
☐ 5 = Not determined.

9. Behavior/Challenging Behavior

9.1 Based on clinical information and the recipient's input, the RN must make an entry using professional judgement. Check only one box under 9.1. If NO choice appears appropriate, check the lowest box that applies and enter the information under "Comments" to describe the recipient's behavior. Only one box must be checked. If no box is checked, a comment is required. If no box is checked and no comment is entered, or if multiple boxes are checked, then the request will be returned.

9.1 Behavior

Use the code that best describes the recipient's behavior. The behavior should be considered within the context of the environment, age, and the life circumstance of the recipient before coding as a "problem." Consider unpredictability, severity, and frequency of the behavior.

- ☐ 0 = Fully cooperative.
- ☐ 1 = Needs prompts/assistance/encouragement to initiate personal care/treatment due to behavior, including noncompliance, but no assistance once care/treatment has begun.
- ☐ 2 = Needs prompts/assistance/encouragement intermittently during personal care/treatment due to behavior, including noncompliance.
- ☐ 3 = Needs consistent, ongoing support/assistance/encouragement throughout duration of personal care/ treatment due to behavior, including noncompliance.
- ☐ 4 = Exhibits one or more of the challenging behaviors under 9.2 less than daily.
- ☐ 5 = Exhibits one or more of the challenging behaviors under 9.2 daily.
- ☐ N = Age appropriate (only for children less than five years old).

Comments: _____

9.2	Only required if box 4 or 5 is checked under 9.1. If a box is required and not checked, a comment is required. Based on clinical information, the RN must make an entry using professional judgement. After carefully reading the descriptions, check all boxes that apply. Also check the appropriate box "4" or "5" under 9.1, Behavior. You must have documented episodes of this behavior in the past 60 days.

9.2	Challenging Behavior

Only complete this section if the recipient is rated a "4" or "5" under Section 9.1, Behavior. These behaviors may occur in addition to behavior(s) described under Section 9.1, Behavior.

☐ 1 Self Injurious Behavior: Engages in behavior that causes injury or has potential for causing injury to his/her own body. Examples include self-hitting, self-biting, head-banging, self-burning, self-poking, or stabbing, ingesting foreign substances, or pulling out hair.

☐ 2 Unusual/Repetitive Habits: Performs unusual stereotypic behavior that inhibits or prohibits participation in daily life activities. Examples include head-weaving, rocking, grinding teeth, spinning objects, or hand-flapping. Collects and hoards items to a point where it interferes with participation in normal daily activities.

☐ 3 Withdrawal Behavior: Excessively avoids others or situations calling for personal interaction to a point where this behavior significantly interferes with participation in normal daily activities. Examples include refusing to talk to others, remaining in his/her room for inordinate periods of time, repeatedly declining opportunities to recreate with others, extreme passivity which leads to victimization.

☐ 4 Hurtful to Others: Engages in behavior that causes physical pain to other people or to animals. Examples include hitting, biting, pinching, scratching, kicking, and inappropriate sexual contacts.

☐ 5 Socially Offensive Behavior: Behavior offensive to others or that interferes with the activity of others. Examples include spitting, urinating in inappropriate places, stealing, screaming, verbal harassment, bullying, and masturbating in public places.

☐ 6 Destruction of Property: Damages, destroys, or break things. Examples include breaking windows, lamps, or furniture; tearing clothes; setting fires; using tools or objects to damage property.

☐ 7 One-on-One Supervision for Self Preservation: Requires constant one-to-one supervision due to behavior for self preservation. *Supervision of the recipient when supervision is the only service provided at the time is not covered by Medicaid*. (For medically necessary one-to-one observation, refer to 11.2, Observation.)

Self preservation is not to be assessed for children less than four years of age because they are dependent on parents by nature of age to ensure their safety. If the child requires more assistance than an adult would typically provide for the child's age, evaluate the child.

If #7 is checked, how frequently does the recipient require one-on-one supervision for self preservation? (Check one)

☐ Less than once a month
☐ 1-4 times per month
☐ 4+ times per month, not daily
☐ Daily, but not hourly
☐ Hourly (one or more per hour during at least 8 hours per day)

Comments: _____

10. Activities of Daily Living (ADL)

10.1 to 10.8 Based on clinical information and the recipient's input, the RN must make an entry using professional judgement. Responses must be based on facts, not assumptions. If the RN determines that a recipient "needs" a specified service, but the recipient was able to manage without having "received" the service, do not check the box. You may explain the needs under "Comments." If the recipient disagrees with the RN's choice, state the recipient's choice under "Comments."

Check only one box in each ADL section 10.1 through 10.8. If no choice appears appropriate, enter information under "Comments" to describe the recipient's functional capacity in this area. If no box is checked, a comment is required. If no box is checked and no comment entered, or if multiple boxes are checked, the request will be returned.

10.1 Dressing

Dressing, such as changing from pajamas to clothes and back to pajamas. Includes application of TED or support hose, but not application of prosthetics or orthotics.

☐ 0 = Independent: Does not need help or supervision of another person in any part of this activity.

☐ 1 = Intermittent Supervision: Needs and receives occasional reminders or instruction, but does not need physical presence of another person at all times to dress. (Record for person who receives assistance to lay out clothes, fasten clothes, or whose performance must be monitored.)

☐ 2 = Constant Supervision: Needs and receives help of another person constantly present during this activity to instruct or watch for problems, but does not need physical help.

☐ 3 = Help of Another: Needs and receives physical help and presence of another person during all of this activity. Recipient is able to physically participate.

☐ 4 = Dependent on Another: Needs and receives physical help from other person to carry out this activity. Recipient is unable to physically participate.

☐ N = Age Appropriate: Only for children less than five years old.

Comments: _____

10.2 Grooming

Grooming, including combing or brushing (but not washing) hair, shaving, brushing/flossing teeth or cleaning dentures, nail care, applying deodorant, inserting and removing contact lenses, inserting and removing hearing aids, and feminine hygiene. Rank based on ability to perform grooming in general, not on ability to perform specific tasks.

☐ 0 = Independent: Does not need help or supervision of another person in any part of this activity.

☐ 1 = Intermittent Supervision: Needs and receives occasional reminders or instruction, but does not need physical presence of another person at all times to groom.

☐ 2 = Constant Supervision: Needs and receives help of another person constantly present during this activity to instruct or watch for problems, but does not need physical help.

☐ 3 = Help of Another: Needs and receives physical help. Recipient is able to physically participate.

☐ 4 = Dependent on Another: Needs and receives physical help from other person to carry out this activity. Recipient is unable to physically participate.

☐ N = Age Appropriate: Only for children less than five years old.

Comments: _____

10.3 Bathing

Bathing or washing the recipient, whether tub, shower, or bed bath. Includes entering tub or shower, wetting, soaping, and rinsing skin and hair, exiting, drying body, and lotioning of skin.

☐ 0 = Independent: Does not need help or supervision of another person in any part of this activity.

☐ 1 = Intermittent Supervision: Needs and receives occasional reminder or instruction, but does not need physical presence of another person at all during bath.

☐ 2 = Needs and receives help in and out of the tub, but can bathe self.

☐ 3 = Constant Supervision: Needs and receives help of another person constantly present during this activity to instruct or watch for problems, but does not need physical help.

☐ 4 = Help of Another: Needs and receives physical help. Recipient is able to physically participate.

☐ 5 = Dependent on Another: Needs and receives physical help from other person to carry out washing and/or drying. Recipient is physically unable to participate.

☐ N = Age Appropriate: Only for children less than five years old.

Comments: _____

10.4 Eating

Eating is the process of getting food into the digestive system. Meal preparation is excluded.

- ☐ 0 = Independent: Eats without help of any kind (drinks from glass and cuts food).
- ☐ 1 = Independent: Eats without help of any kind (drinks from glass and cuts food), but requires assistance in preparing the meal.
- ☐ 2 = Needs and receives personal supervision (reminders) or programming in eating.
- ☐ 3 = Needs and receives assistance to cut meat, arrange food, butter bread, etc., at meal time.
- ☐ 4 = Needs and receives partial feeding from another person (includes drinking from a cup or observation for choking due to frequent incidents of more than once a week).
- ☐ 5 = Needs and receives total feeding from another person.
- ☐ 6 = Needs and receives tube feeding from another person.
- ☐ N = Age Appropriate: Only for children less than three years old.

Comments (include information about any special diet): _____

_____

_____

10.5 Transfers

Transfer is the process of moving between positions (i.e., to/from bed, chair, standing). Transfers for bathing already covered in Section 10.3.

- ☐ 0 = Independent: Requires no supervision or physical assistance to complete necessary transfers. May use equipment such as railings and trapeze.
- ☐ 1 = Intermittent Supervision: Needs and receives guidance only. Requires physical presence of another person during transfer (i.e., verbal cueing, guidance).
- ☐ 2 = Needs and receives physical help from another when transferring. Recipient may participate.
- ☐ 3 = Needs and receives physical help from another or mechanical device. Recipient is unable to participate.
- ☐ 4 = Remains bedfast.
- ☐ N = Age Appropriate: Only for children less than three years old.

Comments: _____

10.6 Mobility

Mobility is the process of moving between locations (i.e., bedroom to living room).

☐ 0 = Independent: Ambulatory without a device.

☐ 1 = Needs and receives help of a device, such as cane, walker, crutch, or wheelchair, and is:
A) Independent in its use ___ B) Needs supervision (cueing or guidance) to use it ___

☐ 2 = Needs and receives physical help from another person. Includes negotiate stairs or home ramp; to lock and unlock wheelchair brakes.

☐ 3 = Needs and receives constant physical help from another person. Includes total dependence with moving wheelchair.

☐ 4 = Remains bedfast.

☐ N = Age Appropriate: Only for children less than 15 months.

Comments: _____

10.7 Positioning

Positioning includes changing body position at a specific location (i.e., sitting up or turning over in bed).

☐ 0 = Positions self in bed or chair without help.

☐ 1 = Needs and receives occasional help from another person to sit up.

☐ 2 = Always needs and receives help from another person to sit up.

☐ 3 = Needs and receives turning and positioning.

☐ N = Age Appropriate: Only for children less than 15 months.

Comments: _____

10.8 Toileting

Bowel and bladder elimination, including use of toileting equipment, such as commode, cleansing self after elimination, and adjusting clothes.

☐ 0 = Independent: Needs no supervision or physical assistance (includes recipient manages dribbling or incontinence).

☐ 1 = Intermittent Supervision: Needs and receives intermittent supervision or programming for safety or encouragement, or minor physical assistance (e.g., clothes adjustment or washing hands). No incontinence.

☐ 2 = Occasional incontinence, not more than once a week.

☐ 3 = Usually continent of bowel and bladder, but needs and receives supervision and/or physical assistance with major parts or all parts of the task, including bowel and/bladder programs and appliance (i.e., colostomy, ileostomy, urinary catheter, bed pan, incontinent product used as precaution).

☐ 4 = Incontinent of bowel and/or bladder, and is not taken to bathroom (includes person who uses incontinent product and is not toileted or catheterized).

☐ 5 = Incontinent of bowel and bladder, but is taken to a bathroom or put on bed pan every two to four hours during the day and as needed during the night.

☐ N = Age Appropriate: Only for children less than three years old.

Comments: _____

11. Medically Oriented Tasks

11.1 Optional. However, if a box is checked, at least one level of provider must be checked under the item. Based on clinical information and the recipient's input, the RN must make an entry using professional judgement. After carefully reading the descriptions, check all boxes that apply. Responses are to be made based on the recipient's needs, not based on what services the provider is furnishing. It may be appropriate to check both home health aide (HHA) and personal care worker (PCW) when a medically oriented task may be delegated to either, depending on availability of trained staff. The medical necessity of a medically oriented task must be established before personal care hours can be approved for reimbursement. Read the directions below.

Check all medically oriented tasks for which the recipient requires care. We expect that the recipient and family members will be taught to perform these tasks when possible. Some of the interventions listed below are routinely delegated to a home health aide (HHA) or personal care worker (PCW), while others are rarely delegated. It is the responsibility of the supervising nurse to be knowledgeable about delegation regulations under the Nurse Practice Act. Indicate the level(s) of caregiver that will provide the care.

11.1 ☐ Seizures

If this box is checked, items A, B, and C are mandatory.

A. Has the recipient had a seizure in the past 12 months? ☐No ☐Yes

B. Does the recipient require active seizure intervention for uncontrolled seizures?

☐No ☐Yes

Interventions:

☐ Take measures to protect from physical harm.
☐ Administer preselected medication.
☐ Administer sliding scale medication.
☐ Other, explain:_____

Who provides the intervention?

☐ RN/LPN ☐ HHA ☐PCW ☐Other:

C. If the recipient has a diagnosis of seizures, please complete the following:

Specific seizure type: _____

Frequency of seizures (per day, per week, or per month): _____

Date of last seizure: _____

Date seizure medication last administered: _____

11.2 ☐ Observation: Observation may be medically necessary when there is a likelihood that immediate medical attention will be required at unpredictable intervals due to the recipient's medical condition. For example, a recipient with active seizures not controlled by medication may require observation. Does not include supervision for physical safety of cognitively impaired or self-destructive persons (see 9.2, Challenging Behavior), or age appropriate supervision of children (i.e., babysitting).

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.3 ☐ Daily Tube Feedings:

☐ Nasogastric ☐ Gastrostomy ☐ Other: _____
☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.4 ☐ Daily Parenteral Therapy: May include intravenous medication, Hickman Catheter, or Heparin lock.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.5 ☐ Wound or Decubiti Care: May include wound or decubitus dressing and care, ostomy dressing, and warm moist packs for inflamed areas.

Wound Stage/Grade: ☐ I ☐ II ☐ III ☐ IV

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.6 ☐ Tracheostomy Care/Suctioning:

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.7 ☐ Oxygen and Respiratory Therapy: Special measures to improve respiratory function, including postural drainage, percussion, blow bottles, IPPB, respirators, suctioning, and oxygen. Excludes standby oxygen unless actually administered weekly.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.8 ☐ Catheters: Routine care is provided at least daily. Include indwelling catheters and intermittent catheterization and dressing of a suprapublic catheter.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.9 ☐ Ostomies: Routine care provided. Include colostomy, ileostomy, ureterostomy, or cystostomy.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.10 ☐ Bowel Program: Bowel program is provided at least two days per week.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.11 ☐ Therapy Program: Recipient receives assistance with therapy, including range of motion, under a therapy plan prescribed by a Physical Therapist, Occupational Therapist, or Speech and Language Pathologist within 12 months.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.12 ☐ Application/Maintenance of Prosthetics and Orthotics: Application of a prosthesis or orthosis as part of a serial splinting program or when the recipient has a demonstrated problem with frequent skin breakdowns which must be closely monitored.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.13 ☐ Complex Positioning: Positioning to reduce spasticity or positioning a recipient who would require complex repositioning when he or she has a demonstrated problem with frequent skin breakdowns; or is part of a therapy treatment program requiring specialized positioning.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.14 ☐ Complex Transfers: Complex transfers are transfers that require the use of special devices when there is an increased likelihood that a negative outcome would result if the transfer is not done correctly, or when a special technique is used as part of a complex therapy program, and the recipient has no volitional movement below the neck, or when simple transfer techniques have been demonstrated to be ineffective and unsafe.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.15 ☐ Complex Feeding: Feeding with special techniques or tools when there is a potential for aspiration and physician orders state special procedures or tools must be used for safe feeding. (Thickening of liquids or small bolus of food positioned in special section of mouth.)

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.16 ☐ Glucometer Reading: Taking glucometer readings and reporting to the supervising RN when the recipient's medical history supports the need for ongoing monitoring for early detection of readings outside of parameters established by the physician.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.17 ☐ Vital Signs: Taking vital signs and reporting to the supervising RN when the recipient's medical history supports the need for ongoing monitoring for early detection of an exacerbation and the physician establishes parameters at which point a change in treatment may be required.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.18 ☐ Skin Care: Skin care when legend solutions, lotions, or ointments are ordered by the physician due to skin breakdown, wounds, open sores, etc. Does not include PRN or prophylactic skin care, which is an activity of daily living task.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.19 ☐ Medication Assistance: Check all boxes that apply.

A. ☐ Recipient requires assistance taking medications.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

B. ☐ Recipient requires administration of medications. "Administer" is the direct application of a prescription drug or device, whether by injection, ingestion, or any other means, to the body of a patient.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

C. ☐ Recipient requires medications to be set up because no pharmacy in the area or no family/volunteers are willing to set up the medications.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

Comments: _____

NOTE: A separate medication list may be attached, as long as all of the requested information is provided. If a separate list is attached, enter "See attached list" under "Medication Name" on the table. If the list is part of another form (HCFA 485), specify where the medications are located on the form.

All providers must complete and update this information at least annually. In addition, providers must update this information for their own information whenever there is a change in medication. Even if your agency does not provide medication assistance or administration, you should inform your staff about medication side effects and have them report any potential side effects observed.

This section (D) is mandatory, except that the provider may refer to the attached list or HCFA 485, #10.

D. In the table, list all legend medications prescribed for the recipient at the time you complete this assessment form, OR attach a separate medication list, such as the HCFA 485. *This information is required even if your agency does not administer or assist with administration*. Include the dosage, frequency, route, and start and stop dates.

Medication Name	Dosage/Frequency	Route	Start/Stop Dates

E. If the recipient has any drug, food, or other allergies, please list them:

_____

_____

_____

11.20 Optional. Enter "N/A" if you do not have additional tasks or problems to describe. We expect "N/A" to be the most common response, but provide this space for any tasks or problems not identified elsewhere.

11.20 Other Task/Problems Not Listed:

Document any other problems which support the need for home care services and the justification for the time which is required to provide the services. Clearly document the intervention. Additional pages may be attached.

_____

_____

_____

_____

12. Staffing

12.1 Enter the most typical weekly schedule of staffing you expect to provide for this recipient. Enter the time your agency provides care, whether personal care, home health aide, nursing, therapist, or homemaker/companion, regardless of funding source. See examples below. A minimum of one entry is required for each level of service requested on the PA/RF unless the staffing for the level of service is sporadic and therefore only explained under 12.3. For example, if the PA/RF requests a home health nurse (HHN) visit on a weekly basis, an entry must be made next to skilled nursing. However, if the HHN visit is only monthly or every other month, it may be listed either under 12.1 or under 12.3.

To clarify the schedule, providers should also include the expected schedule of other "case sharing" agencies. If the recipient will not approve an unavoidable, temporary, schedule change, the provider can still change the schedule temporarily if no harm will come to the recipient. For example, if the PCW is ill, or delayed by bad weather, a later visit to give a bath may be inconvenient to the recipient, but not harmful, and is therefore allowable.

12.1 Anticipated Staffing: Show the scheduled times (e.g., 8 to 10 a.m.) that each agency will provide services and indicate funding source. Staffing may vary on a day-to-day basis at the convenience of the recipient. Agencies cannot vary schedule times without the approval of the recipient.

Level of Care	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Skilled Nursing	11-11:30 am	11-11:30 am	11-11:30 am	11-11:30 am	11-11:30 am	11-11:30 am	11-11:30 am
Home Health Aide	7-11 am		7-11 am		7-11 am	7-11 am	7-11 am
Personal Care Worker	11:30-3 pm 6-10 pm	11:30-3 pm 6-10 pm	11:30-3 pm 6-10 pm	11:30-3 pm 6-10 pm	11:30-3 pm 6-10 pm	11:30-3 pm 6-10 pm	11:30-3 pm 6-10 pm
Case Share w/ ABC		7-11 am HH Aide		7-11 am HH Aide			
Other (Specify) COP Worker	3-6 pm	3-6 pm	3-6 pm	3-6 pm	3-6 pm	3-6 pm	3-6 pm
Other (Specify)							

12.2 Examples of reasons why staffing may change: other caregivers either become available or not available, the frequency with which the recipient leaves the home increases or decreases, or a change in condition is anticipated which may result in staffing changes.

12.2 Is this amount of staffing expected to change within 12 months? ☐ No ☐ Yes

If yes, why? _____

12.3 Optional if 12.1 is complete. Mandatory if 12.1 does not list the scheduled visit for any level of service. In the previous schedule example at 12.1, the recipient required 24 hours of care and four hours of home health aide services were scheduled. If less than four hours of home health aide were scheduled back-to-back with personal care, it would not be granted. If less than four hours of home health aide were scheduled in the AM and personal care hours were scheduled in the PM, explain here why some of the PM care cannot be provided in the AM to maximize the aide visit. If multiple aide visits were indicated, explain here the medically oriented task performed at each visit and why all of the medically oriented tasks cannot be done at a single visit.

"N/A" may be an appropriate response.

12.3 Other clarification on staffing, such as the reason why more than one home health aide visit, or a combination of home health aide and personal care services must be provided in a day when the home health aide visit does not equal four hours for an initial or three hours for subsequent visit:

_____

_____

_____

_____

13. Physician Orders

CARE IS COVERED ONLY WHEN ORDERED BY A PHYSICIAN. Providers do not need to wait for signed orders to send PA requests to Wisconsin Medicaid. The unsigned orders/POC may be sent in prior to obtaining the physician's signature. However, the orders/POC must be signed by the physician and placed in the medical record within 20 days. When a case is ongoing and care will be continued, new physician's orders must be in place before the previous orders expire. Services provided without properly documented orders are subject to recoupment. Licensed and Medicare-certified home health agencies should refer to their licensing and certification requirements regarding physician orders.

14. Wisconsin Medicaid Reimbursement Policy

AN APPROVED AUTHORIZATION DOES NOT GUARANTEE PAYMENT. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval date or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid program payment methodology and policy. If the recipient is enrolled in a Wisconsin Medicaid contracted managed care program at the time prior authorized service is provided, Wisconsin Medicaid program reimbursement will be allowed only if the service is not covered by the managed care program.

15. PCW, HHA, and Travel Time Services

15.1 Enter the following information carefully. The hours and/or visits you enter here for your agency must match the hours and/or visits on your prior authorization request form (PA/RF).

15.1(A) This is the number of hours that your agency wants to provide Wisconsin Medicaid personal care, given as hours per week. It must agree with the hours requested on the PA/RF for procedure code W9900 (personal care-only agencies) or W9903 (dually certified home health and personal care agencies), without travel time included. A number or N/A is mandatory or the request will be returned to the provider.

The time must be reasonable and necessary to provide Wisconsin Medicaid-covered personal care services, which may include medically oriented tasks, activity of daily living (ADL) tasks, and incidental household tasks. Incidental household tasks must be related to medically oriented or ADL tasks and must not exceed 1/3 of the total personal care hours billed per week. The agency is responsible for monitoring the time spent on household tasks.

Regardless of the number of hours approved, providers may only bill for medically necessary covered services. Providers must maintain documentation to support the medical necessity of the services provided. Wisconsin Medicaid will review the tasks provided, including the amount of household task time, via audit.

A. Medicaid PCW care hours/week requested by this provider (from PA/RF): _____

15.1(B) This is the number of hours that another agency wants to provide Wisconsin Medicaid personal care, given as hours per week. It must agree with the hours requested on the other agency's PA/RF for procedure code W9900 or W9903. Ask the case sharing provider to give you this information from their PA/RF. A number or N/A is mandatory or the request will be returned to the provider.

B. Medicaid PCW hours/week from case sharing provider
(obtain this information from the case sharing provider): + _____

15.1(C) This is the number of hours that your agency wants to provide Wisconsin Medicaid HHA, given as hours per week. When converted from visits using the formula listed, it must agree with the number of HHA visits on your PA/RF. Authorization of separate visits of shorter duration may be allowed after RN review determines that certain time-specific tasks are medically necessary and require services to be provided in separate visits. A number or N/A is mandatory or request will be returned to provider.

Regardless of number of hours approved, providers may only bill for medically necessary, covered services. Providers must maintain documentation to support the medical necessity of the services provided. Wisconsin Medicaid will review the tasks provided via audit.

C. HHA hours/week from your agency (any payer)
(HHA initial visit may = up to 4 hours if medically necessary;
HHA subsequent visit may = up to 3 hours if medically necessary): + _____

15.1(D) This is the number of hours that another agency wants to provide Wisconsin Medicaid HHA, given as hours per week. When converted from visits using the formula listed, it must agree with the number of HHA visits on that agency's PA/RF. Ask the provider to give you this information from the PA/RF. A number or N/A is mandatory or request will be returned to provider.

D. HHA hours/week from any provider (any payer)
(HHA initial visit may = up to 4 hours if medially necessary;
HHA subsequent visit may = up to 3 hours if medically necessary): + _____

15.2(A) Add up all hours entered in 15.1, items A through D. Double-check your addition because this figure is a very important part of the PA determination.

A. TOTAL Hours: 15.1, A + B + C + D = _____

15.2(B) Enter the total number of days per week that the services indicated in 15.1(a-d) will be provided. (For example, Monday-Friday is five days; Monday-Saturday is six days, Sunday-Saturday is seven days.) A number is mandatory or request will be returned to provider.

B. Number of days care will be provided per week:
_____

15.2(C) Without additional information to support the amount of time, travel time in excess of one hour per visit, would not be considered reasonable. Refer to the Covered Services section of this handbook for further information regarding travel time. A number or N/A is mandatory or request will be returned to provider. Providers may only bill for actual travel time and must maintain documentation to support time billed.

C. PCW travel time/week requested by the provider (from PA/RF): _____

16. Signatures

16.1 This must be the actual signature of the RN. The agency may submit either the photocopy or the original signature for this form, but the signature on the PA/RF must be the original signature. If a case manager who is not an RN completes the assessment in coordination with an RN, the RN must review and sign the assessment. The signature date may be no earlier than 90 days prior to receipt of the assessment at Wisconsin Medicaid or a current Home Care Update must also be submitted.

16.1 As the RN, I certify that this assessment is a true, accurate, and complete reflection of this recipient's care needs. This assessment was completed by a registered nurse, or case manager in coordination with the registered nurse. Either the recipient or the recipient's responsible party was allowed to participate in the assessment. Medically necessary care will be provided in accordance with the recipient's assessed needs.

RN completing this form: _____
print

_____
signature date

16.2 The recipient or the recipient's representative has the right to participate in the preparation of a care plan. In order to attest to their participation, the recipient or the recipient's representative must sign the original assessment with 62 days of the assessment. The original signed assessment must be kept on file by the provider. If the recipient is not able to participate in the assessment, and the legal representative is not available, a family member or other person involved in the recipient's life may sign the assessment. For example, if the son is the legal representative, but the daughter regularly checks on the mother, the daughter may sign. For persons in a CBRF, the CBRF director or social worker may sign. The provider must retain the form with the original signature.

16.2 I have participated in this assessment. This is a true description of my care needs, or the recipient's care needs, when the signee is the responsible party.

Recipient or Responsible Party: _____
print

_____
signature date

(The signature is not required for submission of the prior authorization request, but must be obtained within 62 days of the assessment and maintained on file.)